Research in Gender and Ethics (RinGs):
Building stronger health systems

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Gender and disability disadvantage women in terms of pro-poor health financing policies in Kenya. How can we improve the system?

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Key messages

- **Without equitable and gender-sensitive health systems that address access barriers, pro-poor health financing reforms will continue to exclude some of the most marginalized including women with disabilities living in poverty.**
- **Gender, disability, and poverty interacted with factors such as disability-unfriendly transportation and health systems structures and negative healthcare worker attitudes; leading to inequitable access to care for women with disabilities living in poverty, who were beneficiaries of pro-poor health financing policies.**
- **To improve access to health services, health financing reforms need to be accompanied by interventions that make health facilities and public transport services accessible to women with disabilities living in poverty.**

Introduction

To extend financing coverage to the poor and vulnerable, Kenya has implemented several pro-poor health policy reforms since 2013. These include: 1) the introduction of a free maternity programme; 2) the abolition of user fees in public primary healthcare facilities (dispensaries and health centers); and, 3) the introduction of a Health Insurance Subsidy Programme (HISP) for the poor.

Health inequity has mainly been linked to differences in economic status, with poorer people facing greater challenges accessing healthcare and reporting poorer health outcomes than the less poor [1]. Other social determinants of health that influence health status and access to care include gender and disability. For example, women are more likely to experience poor health than men [2] and people with disabilities are known to have increased need for healthcare services, but their health needs are more likely not to be met [3].

KEMRI Wellcome Trust undertook a research study to explore how gender (being a woman), and disability intersect to influence the ability of the poor to benefit from pro-poor health financing policies in Kenya. This was a qualitative cross-sectional study done in two counties; one urban and one rural. The study entailed interviewing women with disabilities in the lowest wealth quintile residing in the health and demographic surveillance systems (HDSS) and those who were HISP beneficiaries in the two study counties.

This brief summarizes the key findings from the research and provides recommendations on how access barriers for women with disabilities living in poverty can be addressed.

Key findings

1. Women with disabilities living in poverty often didn't seek healthcare because of their work in the household and caregiving responsibilities

Many women with disabilities living in poverty were the sole household providers and the opportunity cost of seeking care was lost income that would negatively impact on their households. Therefore, they often prioritized earning a livelihood over seeking care. Many women with disabilities living in poverty were also the sole caregivers of their children and they lacked someone to assist them to watch over their children when they sought medical care.

"I usually say, if I go to the hospital, if I leave the market, how will the children eat? Personally, how will I eat? Just that! Because I don't have anyone else who can help me."

Mobility impaired HISP beneficiary, urban area

2. Diminished mobility and the need for assistance created multiple access barriers to healthcare services

Disabilities that imposed mobility challenges limited access to healthcare facilities including those providing care for HISP beneficiaries. This was exacerbated by the long distances to some facilities contracted to provide care to HISP beneficiaries. As such, women with visual and mobility disabilities needed someone to accompany them to the healthcare facility, which in turn doubled their transport costs, making it difficult for them to afford care seeking given their low socio-economic status.

The challenge of high transport costs was compounded by public transportation which was not disability-friendly. Women with mobility and visual disabilities were either denied transport or charged a higher transport fee than abled people because they needed greater assistance when boarding.

"From here to hospital A they (abled people) pay KES 50 but I am transported (using a motorbike) with KES 100 to get to hospital A, to and fro KES 200...It makes me wonder if I am not a human being or what could be wrong with me?"

Mobility-impaired HISP beneficiary, rural area

Without someone to accompany them to a health facility and without money to cater for transport costs, some of the women with disabilities living in poverty failed to access antenatal care and delivered at home despite the existence of the free maternity program.

"This time around she went (to the ANC clinic). The other times she didn't go because there was no one to push her (wheelchair). Right now she goes because her child pushes her (wheelchair)"

Caregiver of a mobility-impaired HDSS participant, rural area

UKaid from the British people

3. Disability-unfriendly health facilities limited the extent to which women with disabilities living in poverty could benefit from healthcare

Health facility layouts, equipment, and services were not structured to meet the needs of women with disabilities. There was absence or shortage of sign language interpreters and guides in public health facilities, and absence of ramps, adjustable beds, and toilets for persons with disabilities.

"If I know am going to the hospital, I don't drink anything that can make me want to go to the toilet because if I go to the toilet, I will have to leave my wheelchair at the door... I use a tricycle, it's a bit wide it can't fit through the toilet door."

Mobility-impaired HISP beneficiary, rural area

4. Prejudice and negative attitudes by health workers and other health system workers disempowered women with disabilities living in poverty and discouraged them from accessing care

Women with disabilities felt that negative healthcare worker attitudes were a result of the additional assistance they required because of their disability. Some healthcare workers also questioned the women's right to be sexually active and to have children. These staff attitudes resulted in negative patient experiences that discouraged them from seeking healthcare services.

"I feel that the healthcare worker is mistreating me because I am disabled, so overall, we (women with disabilities) don't like speaking up" Mobility-impaired HDSS participant, rural area

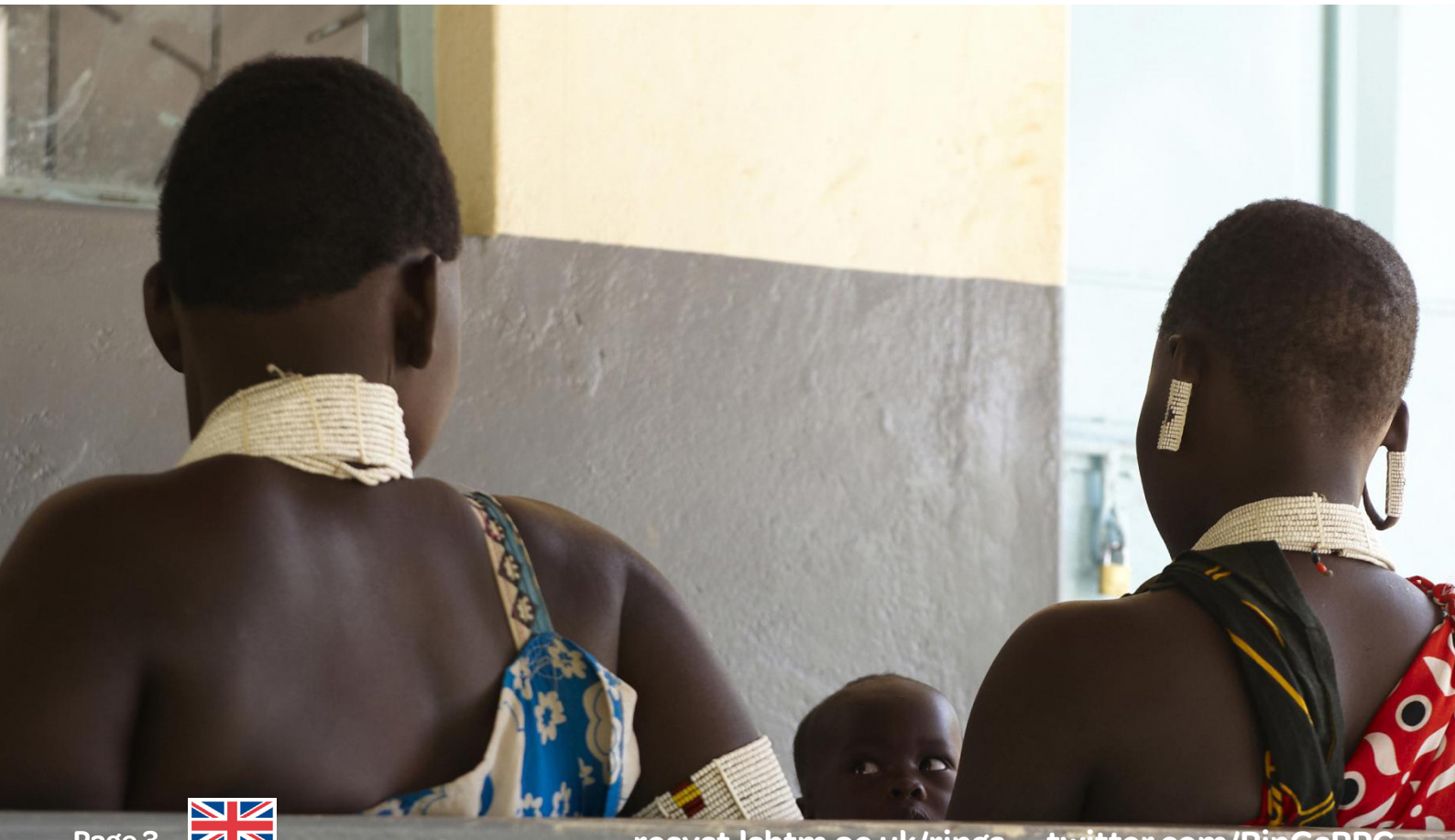
Negative stereotypes against women with disabilities in society led to their exclusion from public participation forums. They were not invited to take part in public forums because they were perceived to be uneducated or they would require assistance to access meeting venues because of their limited mobility. This limited their awareness about health services and their opportunity to contribute to public debate on health service provision.

"There are public meetings of certain kinds that we are excluded from. That's why you find that if we go to hospitals we don't know even where to start...we have never been invited and told this and that or gathered together with others and told these are the developments, so you find some of us are discriminated against"

Visually-impaired HISP beneficiary, urban area

5. Women with disabilities sometimes received preferential treatment from healthcare workers

Some women with disabilities reported that at times, they received preferential treatment from health workers in public health facilities because of their disability. This entailed being allowed to skip queues and therefore being attended to before other clients. In addition, most of the women with disabilities who were HISP beneficiaries received their insurance cards on the day of registration compared to persons without disabilities who had to wait for weeks or months to obtain the insurance/ HISP card. This highlights the importance of an intersectional analysis which posits that social factors intersect in complex ways to sometimes simultaneously create experiences of privilege and disadvantage for an individual.



Conclusions

Gender and disability intersected to limit the extent to which women with disabilities living in poverty could benefit from pro-poor health financing policies. Incorporating an intersectional and gender lens to health systems research is crucial to enhance the understanding of the varying degrees of vulnerabilities in accessing healthcare across social groups, as a result of the interaction of their social locations, such as gender, poverty, and disability, with the underlying socio-economic and political structures.

Recommendations

1. Enhance access to health facilities

To address geographical access barriers, the National Hospital Insurance Fund (NHIF) should ensure that healthcare facilities contracted to provide health services to beneficiaries of pro-poor interventions, such as HISP and the free maternity programme, are close to the locations where beneficiaries reside.

2. Incorporate transport vouchers in pro-poor health financing mechanisms

The NHIF and county governments should consider incorporating transport vouchers in pro-poor health financing mechanisms to alleviate the increased transport costs that persons with disabilities face.

3. Enforce laws that ensure public means of transport are disability-friendly

The National and County governments should work together with the National Council of Persons with Disabilities (NCPWD) to ensure that public service vehicles are disability-friendly as stipulated in the Persons with Disabilities Act, 2003.

4. Improve health system responsiveness to the needs of persons with disabilities

The NCPWD should work closely with the Ministry of Health as envisioned in the Persons with Disabilities Act to ensure availability of preventive, rehabilitative, essential health services and skilled healthcare providers for persons with disabilities. County governments and health facility managers should build cultural competence in health service delivery, especially for maternal and reproductive health services, to ensure it promotes dignity and is non-discriminatory; ensure availability of sign language interpreters, guides, and hospital assistants, and ensure that hospital layouts, equipment, and facilities are disability friendly. Ensuring that health services are responsive to the needs of people with disabilities will ultimately enhance access to quality care for all (including for instance the elderly or able-bodied people with temporary impairment due to injury); and is a step forward towards achieving universal health coverage.

5. Strengthen accountability mechanisms

County governments and health facility managers should ensure availability of effective client feedback and grievance redress mechanisms that target persons with disabilities and other marginalized groups and that are gender sensitive to ensure that women with disabilities living in poverty are also empowered to engage in public participation.

6. Sensitize communities on the needs of persons with disabilities and especially women

Multi-sectoral collaboration is needed to sensitize the society on the needs of people with disabilities living in poverty in order to reduce stigma and discrimination against them. This could entail; raising awareness and addressing negative beliefs about persons with disabilities; advocating for modification of products, services, facilities and buildings to make them accessible to persons with disabilities and encouraging community leaders to support initiatives for persons with disabilities. These initiatives will strengthen family and community support structures that enhance their access to care.

About the brief

Based on

Evelyn Kabia, Rahab Mbau, Kui Muraya, Rosemary Morgan, Sassy Molyneux, Edwine Barasa. How do Gender and Disability Influence the Ability of the Poor to Benefit from Pro-Poor Health Financing Policies in Kenya? An Intersectional Analysis. International Journal for Equity in Health. (In press). Nairobi, 2018.

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3. Meade, M.A., E. Mahmoudi, and S.-Y. Lee, The intersection of disability and healthcare disparities: a conceptual framework. Disability and rehabilitation, 2015. 37(7): p. 632-641.

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Further Information

This brief is a product of the Health Economics Research Unit, KEMRI-Wellcome Trust

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